State of Maryland
Department of Health and Mental Hygiene

Medical Assistance
Personal Care Services Program

RECIPIENT TERMINATION FORM

Recipient's Name M.A.#

Personal Care Services are no longer appropriate for the above named recipient for the following reason(s): Check all that apply.

___ Recipient is no longer eligible for Medical Assistance.

___ Recipient's medical condition has changed to such an extent that personal care services are no longer appropriate.

Specify:

___ Recipient's social situation has changed to such an extent that personal care services are no longer appropriate.

Specify:

___ Recipient has entered a long term care or acute care facility for an anticipated period of 30 days or more.

___ Death of the recipient
Date of Death

___ Other:

Date of original authorization/approval

Date of original start of service

Name of recipient's last provider and provider number

Last date personal care services were rendered by provider

Date recipient notified of termination

Date of Termination

Case Monitor's Signature Date